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GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BHD v. POOBALAN RAJAH

HIGH COURT MALAYA, KUALA LUMPUR
MOHD NAZLAN GHAZALI J
[WRIT NO: WA-22NCC-475-11-2017]
6 DECEMBER 2018

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INSURANCE: *Claims – Fraudulent claims – Seeking to nullify insurance claims and for recovery of insurance pay-out – Whether claimant made fraudulent claim – Whether claimant submitted insurance claim based on false or untrue documents with intention to deceive insurance company – Contradictions between claimant's claim and medical evidence – Whether claimant proved to have been a stroke patient – Admissibility of medical information and records – Whether claimant infringed contractual promise in relevant policies – Whether claimant failed to make full and frank disclosure and breached duty of good faith*

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EVIDENCE: *Adverse inference – Failure to call witnesses – Invocation of s. 114(g) of Evidence Act 1950 – Whether justified*

The defendant bought two insurance policies from the plaintiff, an approved insurance company. The total premiums payable for the first policy was RM9,895.10 and for the second policy RM8,447.70, and permanent disability benefits amounting to RM300,000. On 19 May 2016, the defendant submitted a claim for critical illness benefits under both policies, by reason of his claim that he had suffered from a stroke with left-sided hemi paresis caused by hypertension. The defendant furnished the following key documents (i) CT scan results performed on 2 May 2016 at Hospital Ampang ('the first scan'); (ii) a confidential medical certificate issued by one Dr Ami Fairuza of Hospital Ampang dated 11 May 2016; and (iii) confidential medical certificate signed off by Dr Izzad Emir of the same hospital. Significantly, this certificate, dated 14 November 2016, confirmed that as a result of a neurological assessment performed on 10 November 2016, the defendant had been detected to have slurred speech, left sided muscle wasting with 0-1/5 muscle power on the left upper and lower limbs. The specific diagnosis was identified as Cerebrovascular Accident (CVA) with left hemi paresis. The plaintiff approved the claim and made payment of a total sum of RM1,013,667.69 direct into the defendant's Public Islamic Bank account on 1 December 2016. However, in early October 2017, the plaintiff was alerted by the Social Security Organisation (SOCSO) of SOCSO's suspicion that the defendant may have submitted a fraudulent claim to the plaintiff. Pursuant to inquiries performed by the plaintiff, the following came to light (i) the defendant had been issued with a traffic summons on 12 September 2016 for driving a vehicle with a dirty/faded/fancy number plate, which suggested that the defendant was physically able to drive a car;

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(ii) the plaintiff was informed by one Dr Streetharan that the defendant had consulted him in December 2016 but never indicated he was a stroke victim; (iii) when the defendant registered as a patient at Hospital Columbia Asia Seremban between 23 January 2017 and 27 July 2017, he neither notified the attending doctor that he was a stroke patient nor exhibited any appearance or gait of one; (iv) at the request of SOCSO, Hospital Ampang had also arranged for the defendant to undergo another CT scan following a doctor's examination on him on 25 September 2017 which concluded that the defendant's neurological findings did not correlate with his alleged condition; (v) a second CT scan was conducted on the defendant ('the second scan') which showed that the area of the infarction to the brain as a result of the stroke was different from the one exhibited by the first scan, which suggested that the first scan and the second scan could not have been done on the same individual. Hence, the plaintiff filed this writ action seeking to nullify the insurance claims which were said to have been fraudulently made to the plaintiff by the defendant, and for the recovery of the insurance pay-out effected by the plaintiff to the defendant. Post the filing of the suit, the defendant was arrested by the police in relation to certain reports and was ordered by the police to undergo a third CT scan ('the third scan.') The plaintiff claimed that the defendant did not actually suffer the medical condition that he claimed to have suffered from and that the defendant had submitted a claim based on untrue, false or forged documents with the intention of deceiving the plaintiff into processing and approving the defendant's claim for insurance benefits. It was also the key assertion of the plaintiff that the defendant had purchased the insurance policies from the plaintiff as part of a scheme to make fraudulent claims against insurers based on a fictitious medical condition. The defendant, on the other hand, in his opposition to this suit, denied any wrongdoing on his part and submitted that the plaintiff had failed to prove that it was the defendant who completed or gave data for the issuance of the policy contracts. The defendant also asserted that the plaintiff had failed to prove that the defendant did not suffer from stroke on 2 May 2016 and that the plaintiff's failure to call the medical doctors who treated the defendant and the non-calling of the plaintiff's investigation team justified an adverse inference be drawn against the plaintiff's case.

Held (allowing plaintiff's claim):

(1) The substantial differences in both the first and second CT scans, where the infarcts present in the first scan were not visible or appear in a different location in the second scan clearly showed that the two results must physically and medically be in respect of two different patients. The third scan confirmed that the defendant had a normal healthy brain which did not show the defendant as being a stroke patient. Not only were the specific infarcts present in the first scan did not correlate to the

results of the second scan, but the infarcts in the first scan and the second scan too were nowhere to be detected in the third scan. Thus, despite the admission by the defendant that he did undergo three CT scans, the results of these three scans, notwithstanding the records stating them to be in relation to the patient identified as the defendant, would lead to the inescapable and inevitable conclusion, in light of the vastly different findings on the three CT scans, that these three CT scans must in actual fact have been performed on three different patients, and not just one person. (paras 40-42 & 44)

(2) In view of the process, it would have been relatively easy for the defendant to register his name at the counter but thereafter arrange for another person to pretend to be the defendant and for this person to present himself at the waiting area outside the CT scan room. The only explanation for what happened in the instant case was that another patient underwent the first scan and the second scan pretending to be the defendant. The version that the defendant gave his appointment card and form to someone else to impersonate him in respect of the first scan and the second scan was compelling. It was only the third scan and not the first two which actually examined the defendant. The third scan was taken while the defendant was in police custody and his attendance at the hospital for the third scan was accompanied by and under the custody of police officers. (paras 49, 50, 52 & 53)

(3) The defendant's resistance to the claim by the plaintiff became considerably weakened when evidence of the other physical medical examinations done by a number of doctors on the defendant again did not yield results which were consistent with the kind of stroke as submitted by the defendant to the plaintiff on the basis of the first scan. Evidence was forthcoming from other doctors that the defendant did not exhibit or had any signs or gait of a stroke patient, or that he had any muscle wasting and contractures. (paras 58, 60 & 63)

(4) The defendant himself had signed and furnished four copies of irrevocable letters of authorisation to enable the plaintiff to obtain further information regarding the defendant's health and medical condition. The defendants further authorised any doctor, medical practitioner, physician or hospital to supply information to the plaintiff in the very claim form that the defendant submitted to the plaintiff. The doctors themselves gave evidence in court, and the documents were therefore plainly admissible. The legal principle of estoppel should rightfully operate to prevent and disapprove of the inequitable conduct of the defendant in attempting to mount such a challenge at this juncture. Even if it the evidence was illegally obtained, which was certainly not

the case, such evidence was still admissible if it was relevant to the material facts in issue. The law does not recognise the convenient and self-serving argument that one does not actually understand what one signs (paras 66, 68, 70, 72, 73 & 75)

(5) By reason of the false claims which were made by the defendant intentionally and with deliberate orchestration of a scheme involving other parties who might or might not have themselves been unaware of the fraudulent nature of the same, the defendant had infringed his contractual promise as contained in the relevant policies. The defendant owed a contractual and statutory duty to the plaintiff to make full and frank disclosure of all material facts in the proposal form and it was an implied term in the policies that the defendant would not make a claim by fraudulent means or be in breach of his duty to act in good faith. The defendant had also not disclosed that he had multiple insurance policies with other insurers when he applied to purchase the insurance policies from the plaintiff. The pattern suggested that the purchase of the multiple policies was part of a scheme to defraud various insurance companies. There was a blatant failure on the part of the defendant to make a full and frank disclosure of all material facts in the proposal form which represented a form of a breach of the policies. (paras 91, 93, 97, 99 & 101)

(6) The defendant chose not to call any witnesses to support his defence. He did not call his sister whom he alleged was the driver of the car who actually committed the summons offence. Neither did he call the two 'uncles' who accompanied him for the first two scans or any person to offer any testimony about the recovery he allegedly experienced. Further, there was a failure to call any medical expert to attempt to rebut the overwhelming medical evidence tendered and testified by the plaintiff's witnesses, namely the doctors. There was thus justification for the invocation of the presumption in s. 114(g) of the Evidence Act 1950 that the witnesses were not called because their testimony would draw an adverse inference to the defendant's case. (paras 105-108)

Case(s) referred to:

Fui Lian Credit & Leasing Sdn Bhd v. Kim Leong Timber Sdn Bhd & Ors [1991] 1 CLJ 522; [1991] 2 CLJ (Rep) 614 HC ***(refd)***

Hap Seng Credit Sdn Bhd v. Mohamed A Ralim & Ors [2015] 1 LNS 1227 HC ***(refd)***

Juahir Sadikon v. Perbadanan Kemajuan Ekonomi Negeri Johor [1996] 4 CLJ 1 CA ***(refd)***

KGN Jaya Sdn Bhd v. Pan Reliance Sdn Bhd [1996] 2 CLJ 611 CA ***(refd)***

Liberty Insurance Bhd v. Marrison Sidar & Anor [2019] 8 CLJ 380 HC ***(refd)***

Sinnaiyah & Sons Sdn Bhd v. Damai Setia Sdn Bhd [2015] 7 CLJ 584 FC ***(refd)***

Wako Merchant Bank (Singapore) Ltd v. Lim Lean Heng & Ors [2000] 4 CLJ 223 HC ***(refd)***

Legislation referred to:
Evidence Act 1950, ss. 73A, 114(g)
Financial Services Act 2013, Schedule para 5
Penal Code, s. 420

For the plaintiff - Andrew Teh & Sara Anthony; M/s Wong Lu Peen & Tunku Alina
For the defendant - Jason Mathews, Francine Rajendram & IJ Ng; M/s Mathews & Assocs

Reported by Suhainah Wahiduddin

JUDGMENT

Mohd Nazlan Ghazali J:

Introduction

[1] This is a writ action for various declaratory reliefs which essentially sought to nullify the insurance claims which were said to have been fraudulently made to the plaintiff by the defendant, and for the recovery of the insurance pay-out effected by the plaintiff to the defendant.

[2] Following the completion of trial, I ruled for the plaintiff and highlighted the key reasons for my decision. This judgment contains the full reasons for my decision.

Key Background Facts

The Policies, The Claim And The Pay-out

[3] The plaintiff is an approved insurance company. The defendant, a male individual, bought two insurance policies from the plaintiff. The total premiums payable for the first policy was RM9,895.10 and for the second policy, RM8,447.70. Both were for the basic assured sums of RM200,000 each, as well as a rider on, crucially for present purposes, total and permanent disability benefits amounting to RM300,000.

[4] On or about 19 May 2016, the defendant submitted a claim for critical illness benefits under both policies, by reason of his claim that he had suffered from a stroke with left-sided hemiparesis caused by hypertension.

[5] In making the claim to the plaintiff, the defendant also furnished the following key documents. First, and most critically, is the CT scan results performed on 2 May 2016 at Hospital Ampang ("the first scan"). Secondly, a confidential medical certificate issued by Dr Ami Fairuza Abdul Aziz of Hospital Ampang dated 11 May 2016. Subsequently, the defendant handed over to the plaintiff another confidential medical certificate signed off by Dr Izzad Emir Ismail of the same Hospital Ampang.

[6] Significantly, this certificate, dated 14 November 2016 confirmed that as a result of a neurological assessment performed on 10 November 2016, the defendant had been detected to have slurred speech, left-sided muscle wasting with 0-1/5 muscle power on the left upper and lower limbs. The

specific diagnosis was identified as Cerebrovascular Accident (CVA) with left hemiparesis. No less importantly, the prognosis was that it was likely to be permanent.

[7] After having evaluated the claims made by the defendant, the plaintiff approved the claim and make payment of a total sum of RM1,013,667.69 direct into the defendant's Public Islamic Bank account on 1 December 2016.

The Suspicion Of Fraudulent Claim

[8] The plaintiff first got wind of a possible issue on the claim made by the defendant when the former was alerted by the Social Security Organisation (SOCSO) early October 2017 of SOCSO's suspicion that the defendant may have submitted a fraudulent claim to the plaintiff.

[9] Pursuant to inquiries performed by the plaintiff, the following came to light. First, the defendant had been issued with a "type 2" traffic summons on 12 September 2016 for driving a vehicle with a dirty/faded/fancy number plate. This suggested that the defendant was physically able to drive a car on 12 September 2016.

[10] Secondly, the plaintiff was informed by one Dr Streetharan of Klinik Sri Singgam at Sungai Pelek Selangor that the defendant had consulted him in December 2016 but never indicated he was a stroke patient. And neither did Dr Streetharan observe any stroke-related disability affecting the defendant.

[11] Similarly, thirdly, when the defendant registered as a patient at Hospital Columbia Asia Seremban between 23 January 2017 and 27 July 2017, he neither notified the attending doctor that he was a stroke patient nor exhibited any appearance or gait of one. Further, the medical examinations conducted by the doctor too did not produce results which were consistent with a patient who had suffered stroke with left side hemiparesis, as claimed by the defendant.

[12] Fourthly, at the request of SOCSO, Hospital Ampang had also arranged for the defendant to undergo another CT scan following a doctor's examination on him on 25 September 2017 which concluded that the defendant's neurological findings did not correlate with his alleged condition.

[13] This resulted in a second CT scan conducted on the defendant ("the second scan"). This was done at Hospital Ampang on 27 September 2017. Crucially the second scan shows that the area of the infarction (damage) to the brain as a result of the stroke is different from the one exhibited by the first scan. This according to the plaintiff suggested that the first scan and the second scan could not have been done on the same individual.

[14] The plaintiff lodged a police report on the matter on 3 November 2017.

[15] The instant writ action was then filed by the plaintiff on 24 November 2017.

[16] Post the filing of this suit, the defendant was even arrested by the police in relation certain reports and was ordered by the police to undergo a third CT scan. This happened on 13 March 2018, also at Hospital Ampang ("the third scan").

The Reliefs Prayed For

[17] The crux of the claim of the plaintiff against the defendant is for a declaration that the claims made by the defendant for the illness he asserted to have suffered from is fraudulent and for the monies paid to the defendant be refunded to the plaintiff.

[18] For completeness and to better appreciate the case of the plaintiff, its claims for reliefs in full, as they appear in the amended pleadings, are as follows:

17.1 A declaration that the claim submitted by the Defendant under Policy No. 1016370809 and Policy No. 1019850849 is fraudulent and/or dishonest.

17.2 A declaration that the claim submitted by the Defendant under Policy No. 1016370809 and Policy No. 1019850849 is in breach of the duties pleaded at paragraphs 7 and 8.

17.3 A declaration that the Defendant holds the sum of RM1,013,667.69 upon a constructive trust for the Plaintiff.

17.4 Further or alternatively, a declaration that the Defendant's said Condition did not continue throughout the Time Period and/or the said Condition ceased to be permanent as pleaded herein, and accordingly the Plaintiff is entitled to the refund of the Policy Monies.

17.5 An order that the Defendant pays the Plaintiff the sum of RM1,013,667.69.

17.6 A declaration that the Plaintiff is entitled to trace the Policy Monies in the hands of the Defendants or elsewhere and thereafter apply to discharge the judgment sum of the Defendant to the Plaintiff.

17.7 An inquiry into what assets of the Defendant, movable or immovable and whether owned legally or beneficially by the Defendant and whether in his own name or not and whether solely or jointly owned, were acquired out of proceeds of the Policy Monies which is held by the Defendant as constructive trustee for the Plaintiff.

17.8 An order that all movable assets held by the Defendant and/or whomsoever consequent upon the inquiry into assets pursuant to paragraph 17.7 herein as constructive trustee be delivered up to the Plaintiff.

17.9 An order that all immovable assets held by the Defendant and/or whomsoever consequent upon the inquiry into assets pursuant to paragraph 17.7 herein so sold by judicial sale by public auction and the proceeds paid to the Plaintiff after deducting all costs and expenses of the auction.

17.10 Interest on all monetary claims above pursuant to Section 11 of the Civil Law Act 1956;

17.11 Interest at the rate of 5% per annum on all the above monetary claims from the date of Judgment until the date of full and final settlement;

17.12 Costs on a solicitor-client indemnity basis; and

17.13 Such further order or other relief as this Honourable Court deems fit and proper.

Issues To Be Tried

[19] Although the items identified by counsel for parties as constituting issues to be tried are many and various, in essence and substance they may be grouped into only a few real issues to be tried.

[20] First, the overarching issue for determination of this court is whether the defendant had suffered stroke with left side hemiparesis which produced a "neurological sequelae of a permanent nature". This was the basis of his insurance claim which was acted on and approved by the plaintiff.

[21] Secondly, in the event it is determined that the defendant had indeed suffered from the stroke, the case of the plaintiff would come to an end. Conversely, if the defendant is ascertained not to have so suffered, the issue would then be whether the defendant had furnished a claim for insurance benefits fraudulently or in violation of his contractual promises under the pertinent policies.

[22] The third issue, which would only be applicable if the second issue is found against the defendant, is whether the defendant had purchased the policies as a scheme to make a fraudulent claim against insurers based on a fictitious medical condition.

Summary Of The Contentions Of The Litigants

[23] The case of the plaintiff is simple and straight forward. It is that the defendant did not actually suffer the medical condition that he claimed to have suffered from. This was the claim for insurance benefits furnished by the defendant.

[24] The defendant, according to the plaintiff, submitted a claim based on untrue, false or forged documents with the intention of deceiving the plaintiff into processing and approving the defendant's claim for insurance benefits. The *modus operandi* of this deceitful conduct, so the plaintiff claims, is by the

defendant having deliberately arranged for another person as a patient to undergo the computer tomography or CT scan on the defendant's behalf or for the CT scan results to be replaced with another patient's. And this was perpetrated not once, but twice.

[25] It is also the key assertion of the plaintiff that the defendant had purchased the insurance policies from the plaintiff as part of a scheme to make fraudulent claims against insurers based on a fictitious medical condition.

[26] The defendant on the other hand, in his opposition to this suit instituted by the plaintiff, denied any wrongdoing on his part and submitted that the plaintiff had failed to prove that it was the defendant who completed or gave data for the issuance of the policy contracts.

[27] Secondly, and more significantly, the defendant also asserted that the plaintiff had also failed to prove that the defendant did not suffer from stroke on 2 May 2016. According to the defendant, the plaintiff's failure to call the medical doctors who treated the defendant and the non-calling of the plaintiff's investigation team justify an adverse inference be drawn against the plaintiff's case.

[28] In essence, the defendant also contended that the plaintiff did not show that the defendant had recovered to a condition before the stroke, or that the differences in the three CT scans is attributed to the defendant. Also the defendant made much of the argument that the plaintiff's evidence and its witnesses are tainted with wilful concealment and hearsay evidence.

The Trial And The Witnesses

[29] At the trial, the plaintiff called 14 witnesses. They were:

(i) ASP Ahmad Faizal bin Abdul Ghani, a traffic police (PW1);

(ii) Inspector Norulshuhadad binti Yahaya, a police investigating officer (PW2);

(iii) Thasha Jayamanogaran, a journalist with the Malay Mail (PW3);

(iv) Nur Izzati Izzah Nadzi, a journalist with Utusan Malaysia (PW4);

(v) Choo Wei Yoong, a claims manager with Hong Leong Assurance Berhad (PW5);

(vi) Mashud bin Rusdi, an assistant manager with Public Bank Islamic Berhad (PW6);

(vii) Chin Jia Gi, an assistant vice president, claims department with the plaintiff company (PW7);

(viii) Murni Wan Omar, a journalist with Berita Harian / New Straits Times Press (SP8);

(ix) Nurul Azahar bin Hussien, the director of registration department, Registrar of Societies (PW9);

(x) Dr Chew Gim Bee, medical officer, Columbia Asia Hospital (PW10);

(xi) Dr Hjh Rosaida binti Hj Mohd Said, Head of Department, Consultant Physician, Gastroenterologist & Hepatologist, Hospital Ampang (PW11);

(xii) Dr Emilianah binti Saidil, radiologist, Hospital Ampang (PW12);

(xiii) Ganaraj a/l Rajaratnam, head of investigations, AIA Berhad (PW13); and

(xiv) Dr Sreetharan a/l Muthusamy, Klinik Sri Singam (PW14).

[30] The defendant on the other hand chose not to call any witnesses. He gave evidence on his behalf.

Evaluation And Findings Of This Court

Whether The Defendant Suffered A Stroke

The Coverage

[31] The plaintiff's key assertion is that the defendant had submitted false claims under the two policies purchased from the plaintiff. The falsehood concerns the basis of the claim which relates to the medical condition covered under the policies. Specifically, stroke. In other words, the plaintiff is saying that despite the claim by the defendant that he suffered from a stroke which entitled him for insurance payments, the defendant was not actually afflicted by stroke.

[32] In the first place, it is common ground that stroke is an event which is plainly covered by the policies purchased by the defendant. Thus cl. 2(2) which appears in both policies defined the "covered events" as including stroke which is primarily defined (apart from exclusions which are irrelevant for present purposes) as follows:

> A cerebrovascular accident or incident producing a neurological sequelae of a permanent nature, having lasted not less than three (3) months. Infarction of brain tissue, haemorrhage and embolisation from an extra-cranial source are included. The diagnosis must be based on changes seen in a CT scan or MRI and certified by a consultant neurologist.

[33] The key question for determination is whether the defendant did suffer stroke with left side hemiparesis (weakness or paralysis), as claimed by the defendant, which produced what was stated in the policies in medical terms "neurological sequelae of a permanent nature." Or in other words, stroke which caused some form of permanent disability. The stroke suffered by the defendant must produce nerve damage of a permanent nature.

[34] This was the basis of the insurance claims made by the defendant and paid out by the plaintiff. The defendant had made the insurance claims in question to the plaintiff based on the report of the first scan. And this is the premise of the case of the plaintiff of a fraudulent claim against the defendant.

The Differences In The Results Of The Three CT Scans

[35] It should be stated that whilst the ailment of a stroke with left side hemiparesis was indeed disclosed in the results of the first scan which had been submitted to the plaintiff, the second scan and the third scan exhibited neurological findings which did not at all correspond with the first scan results.

[36] The undisputed fact is that there are three CT scan reports which are attributed to the defendant as the patient, and all these CT scans were performed at the same hospital. Neither is it denied that the three reports are as a matter of plain fact different from one another. Crucially however, the defendant himself claimed that he had undergone the three CT scans.

[37] I find that there is sufficient evidence to support the claim of the plaintiff that the first scan and the second scan are not in respect of the defendant but instead are from different individuals or patients. PW11 in particular testified that the shape of the skull in both these CT scans are different. One was rounded, but the other, supposedly of the same patient, was elongated.

[38] Not only that. As testified by PW11, the results of the second scan show a severe stroke with an old infarct which is located on the left side of the brain instead of the right. This means, medically and in physical terms, that any changes or weaknesses in the body will be experienced on the reverse side, which should be the right side.

[39] However, the defendant's claim is based on a stroke with left side hemiparesis, pursuant to the findings of the first scan - on which the claims were made to the plaintiff and for which payment was effected to the defendant - which exhibits a stroke on the right side of the brain.

[40] The substantial differences in both the first and second CT scans, where the infarcts present in the first scan are not visible or appear in a different location in the second scan clearly therefore shows that the two results must physically and medically be in respect of two different patients.

[41] In addition, and more crucially, and as testified by PW11, the third scan confirms that the defendant has a normal healthy brain which does not show the defendant as being a stroke patient. Infarctions caused death or irreversible damage to the relevant tissue.

[42] Thus, despite the medical fact that they are permanent and cannot simply disappear, curiously, not only are the specific infarcts present in the first scan do not correlate to the results of the second scan, but that the infarcts in the first scan and the second scan too are nowhere to be detected in the third scan.

[43] The third scan shows the neurological findings of a person with a normal brain and who is not a stroke patient.

[44] Thus, despite the admission by the defendant that he did undergo three CT scans, the results of these three scans, notwithstanding the records stating them to be in relation to the patient identified as the defendant, would lead to the inescapable and inevitable conclusion, in light of the vastly different findings on the three CT scans, that these three CT scans must in actual fact have been performed on three different patients, and not just one person.

The Process To Undergo Scanning

[45] In order to appreciate the possibilities involved in the instant case, in particular to answer the question as to how it was possible that the scan results of purportedly the same person demonstrate considerably different neurological findings on the very delicate matters relating to the human skull and the brain, evidence had also been adduced, primarily from PW11 and PW12 as to the process that a patient had to follow in order to have the CT scan performed on him.

[46] It is the clear testimony of PW12 that a patient who has to undergo a CT scan must first have with him a form for such purpose and an appointment card. The patient will secondly have to register with the counter staff in the radiology department and the staff will check the patient's name in the system.

[47] Thirdly, once the name is verified, the patient will be required to wait in the waiting area for his name to be called. Fourthly, the radiographer will when ready call out the patient's name. Fifthly, and this is crucial, the person who responds to the same thus confirming to be the person whose name is called out by the radiographer will be asked to sit on the scan table and the radiographer will key in the patient's name into the scanning system.

[48] This means that there is no additional verification of the identity of the person who comes to the scan table for as long as that person holds the patient card and the form is the named patient.

[49] The case of the plaintiff is that the only explanation for what had happened in the instant case is that another patient underwent the first scan and the second scan pretending to be the defendant. I agree. For a number of reasons.

Evidence Of Another Patient Undergoing The First Two Scans

[50] First, in view of the process (which probably may not be dissimilar to that in other hospitals) it would have been relatively easy for the defendant to register his name at the counter but thereafter arrange for another person to pretend to be the defendant and for this person to present himself at the waiting area outside the CT scan room. The person would have been given the form and the appointment card by the defendant and would just need to respond to the name of the defendant being called by the radiographer for the scanning process to be initiated.

[51] Secondly, I cannot but agree with the submission of the plaintiff that based on the evidence given by PW11, it would be impossible for there to be any confusion with the scan digital images by the hospital in view of the fact that the entire process is regulated by the patient's name, appointment card and form. In particular, at the keying in process into the scanning machine, the patient's name is immediately entered into the system and the images are locked to the patient's name and stored into the system. This leaves the only other plausible explanation. That other persons claimed to be the defendant and underwent the scanning.

[52] Thirdly, the defendant confirmed he was in the hospital on all three occasions and underwent the process himself. And the version that he gave his appointment card and form to someone else to impersonate him in respect of the first scan and the second scan is compelling.

[53] For I am satisfied that it was only the third scan and not the first two which actually examined the defendant. This is given the undisputed fact that the third scan was taken while the defendant was in police custody. His attendance at the hospital for the third scan was accompanied by and under the custody of police officers.

[54] This was also the testimony of PW12. In other words, he could not, on this specific occasion have orchestrated for another person to pretend to be him in that situation.

[55] In contradistinction, for the first scan and the second scan, the defendant had on the flimsiest of reasons declined to have the scans done immediately but only arranged to have them in subsequent days. This had given the defendant the opportunity to manipulate the process at the hospital and arrange to have another person to take the place and name of the defendant for the first two scans.

[56] I mentioned flimsy because PW11 testified that when she examined him on 25 September 2017 (due to request which originated from SOCSO) and suggested he undergo a second scanning and for that purpose get admitted, the defendant refused to have it done the same day, and when later cross-examined on this, the defendant offered the explanation that he could

not do the same day because his family members were present and that he wanted to send them home first. I cannot but agree with the plaintiff's submission that this excuse is wholly unconvincing because he was supposed to be the stroke patient who cannot move the left side of his body. And I also agree that he must have wanted more time to arrange for another person to pretend to be him to undergo the second scan.

[57] Indeed, after all, the defendant himself testified that he was accompanied by an "uncle" for the first scan, and another "uncle" for the second scan. Yet nobody was called by the defendant to support this testimony.

Examinations On The Defendant Show His Neurological Profile Could Not Have Been As Per The First Scan And The Second Scan

[58] In addition, the defendant's resistance to the claim by the plaintiff becomes considerably weakened when evidence of the other physical medical examinations done by a number of doctors on the defendant again did not yield results which were consistent with the kind of stroke as submitted by the defendant to the plaintiff on the basis of the first scan.

[59] Thus, for one, PW11 gave evidence that when she examined the defendant on 25 September 2017, the defendant claimed he could not move the left side of his body including left hand and left leg. He also said to be suffering from a slurred speech.

[60] However the examination on the defendant as conducted by PW11 produced results which did not support the defendant's complaints. First, the overall condition was found to have been totally inconsistent with that of a patient who genuinely had a serious stroke and having weakness for almost a year. Yet in the instant case, PW11 discovered that there was no muscle wasting and no contracture. Although muscle power was exhibited by the defendant, likely to have been feigned, to be zero, his reflexes and muscle tone are normal.

[61] Secondly, PW11 testified that it was unlikely for the defendant to have suffered from slurred speech because slurred speech would always be attributed to injury to the left side of the brain which also means that any physical weakness would be felt on the right side. As such, since the defendant complained of left side weakness, the injury to the brain must have been on right side.

[62] PW11 also stated that it was unlikely for the defendant to have slurred speech because slurred speech is always due to injury to the left side of the brain which means the weakness if any will be felt on the right side. Since the defendant complained of left side weakness, the defendant could not have experienced slurred speech. Moreover, the defendant's admission records in May 2016 did not disclose that the defendant in fact did have any slurred speech.

[63] Further, evidence was also forthcoming from another doctor practising in another medical institution. PW10 testified that only at his third visit on 26 July 2017, did the defendant reveal that he was a stroke patient. This surprised PW10 given the fact that when the defendant consulted him on the two previous occasions, the first on 11 April 2017 and the second on 15 July 2017, the defendant did not exhibit or have any signs or gait of a stroke patient. On top of that, PW10 even performed a physical examination on the defendant which could not be validly said to have found conclusive signs which correlated to the defendant's assertion that he is a stroke patient.

[64] Yet another testimony from a different doctor cast even more serious doubts over the defendant's claim was given by PW14. The defendant consulted with him on 29 December 2016 for fever, and PW14 had no record nor recollection of the defendant being a stroke patient in his clinic.

Reliance On Medical Testimony Valid

[65] All the CT scans and the doctors' answers to the plaintiff's questionnaire are placed in Part B, and PW11's questionnaire and the attachment thereto which concerned the second scan had been placed in Part C. In view of the testimony of PW11, I had no hesitation in admitting them into evidence.

[66] The defendant's objection to their admissibility on account of the contention that the disclosure of the CT scan results and other medical records were made without the defendant's consent simply does not hold water because not only have these documents all been marked, the defendant himself had signed and furnished four copies of irrevocable letters of authorisation to enable the plaintiff to obtain further information regarding the defendant's health and medical condition. This included attending doctors, medical officers and treating hospitals.

[67] The letter of authorisation and consent to obtain further information for non-death was thumbprinted on 10 August 2016 by the defendant as the insured in respect of the policies stated clearly as follows:

> LETTER OF AUTHORISATION/CONSENT
>
> To whom it may Concern
>
> Dear Sir/Madam
>
> I, The Life Assured, hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organization, institutions or person that any have any records or knowledge of my/Life Assured's health or medical history ("Information Provider"), to provide such information to GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("the company") and its authorised service provider and/or its employees in order to process my insurance claim.

I, the Life Assured/Assured, expressly waive on behalf or myself or any person who shall any claim or interest in any policy hereunder, all provision of law or professional ethics forbidding any Information Provider from disclosing any Information acquired while attending to me in a professional capacity. This authorisation shall irrevocably bind my successors and assigns and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be effective and valid as the original.

This authorisation/consent is irrevocable and a copy of it will have the same effect and validity as the original.

... .

[68] Similarly, the defendant had also authorised any doctor, medical practitioner, physician or hospital to supply information to the plaintiff in the very claim form that the defendant submitted to the plaintiff. This of course is standard arrangement to be found in similar insurance coverages.

[69] The authorisation and /consent in the claim form was given by the defendant who signed off on the claims form on 5 May 2016. The pertinent clauses read as follows:

CONFIRMATION ON GST REGISTRATION, DECLARATION & AUTHORISATION BY THE LIFE ASSURED / ASSURED (POLICYOWNER) / CLAIMANT

I, the Life Assured/Assured (Policyowner) / Claimant understand and agree that, GREAT EASTERN LIFE ASSURANCE (MALAYSIA) BERHAD (93745-A) ("The Company") shall rely on my confirmation in respect of the Policyowner /Policyholder GST registration provided above GST tax credit purposes. I further agree, that in the event any action, claim or proceeding is taken against the Company and/or any fine, charge, penalty or any other GST liability imposed on the Company as a result of relying on my incorrect confirmation on the Policyowner /Policyholder GST registration, I undertake to hold the Company harmless and keep the Company indemnified top the fullest extent permitted by law.

I declare the above answers are true and correct and I agree that if I have made, or shall make any untrue statement, or suppressed or concealed any material fact; my/the Life Assured's right to be compensated shall be absolutely forfeited. I,the Life assured / Assured (Policyowner) / Claimant hereby authorise and give my consent to any doctor, medical practitioner, physician, hospital, laboratory, surgeon, nurse, medical staff, clinic or insurance company or other organization, institutions or person that any have any records or knowledge of my/Life Assured's health or medical history ("Information Provider"), to provide such information to The Company authorised service provider and/or its employees in order to process my insurance claim. I, the Life Assured/Assured (Policyowner)/Claimant, expressly waive on behalf of myself or any other person who shall have any claim or interest in any policy hereunder, all

A provision of law or professional ethics forbidding any Information Provider from disclosing any information acquired while attending to me in a professional capacity.

I, the Life Assured/Assured (Policyowner)/Claimant, hereby authorise and give my consent, to the deduction of monies due to the Company
B from the claim proceeds payable pursuant to any policy hereunder, including but not limited to any Automatic Premium Loan, Cash Loan, overdue interests, premium due, advance benefit paid, erroneous and/or payment made in excess of any claim amount. This authorisation shall irrevocably bind my successors and assignees and shall remain valid notwithstanding my death or incapacity, and a copy of this form shall be
C effective and valid as the original.

[70] In any event, the doctors themselves gave evidence in court. The documents are therefore plainly admissible (see also s. 73A of the Evidence Act 1950).

D **[71]** And the defendant does not deny signing these authorisations. He cannot now object to the disclosure of the documents or information obtained by the plaintiff from the doctors, hospitals and other organisations.

[72] In my view, the legal principle of estoppel should rightfully operate to prevent and disapprove of the inequitable conduct of the defendant in
E attempting to mount such a challenge at this juncture. Reference ought to be made to the decision of the Court of Appeal in *KGN Jaya Sdn Bhd v. Pan Reliance Sdn Bhd* [1996] 2 CLJ 611; [1996] 1 MLJ 233, which held as follows:

F We are of the view that it would be a travesty of justice if we were to accede to the appellant's arguments. We are left in no doubt that the undisputed facts of this case admit of the conclusion that the respondent was, by the conduct of the appellant, lulled into the belief that the appellant had no challenge to the accounts, leave alone the legal relationship between the parties.

G To put it another way, the appellant, by its silence coupled with other circumstances of the case, encouraged the respondent to believe that it intended to raise no challenge to the existence of a prior legal relation between the parties or to the figure which the account showed as owing by it. Having done so, it ought not to be permitted to now contend otherwise.

H It follows that it does not, therefore, lie in the mouth of the appellant to now deny the respondent's claim. It would be plainly inequitable to do so. An examination of the facts leads us to this conclusion. The legal basis upon which such a conclusion may be sustained is well-settled and it is now beyond question. See *Boustead Trading [1985] Sdn Bhd v. Arab-*
I *Malaysian Merchant Bank Berhad* [1995] 4 CLJ 283; [1995] 3 MLJ 331.

[73] Even if the evidence was illegally obtained, which is certainly not the case, such evidence is still admissible if it is relevant to the material facts in issue (see *Wako Merchant Bank (Singapore) Ltd v. Lim Lean Heng & Ors* [2000] 4 CLJ 223; [2000] 3 MLJ 401).

[74] The defendant, in an attempt to respond to allegation of false information provided in the application form such as on level of income and existence of policies with other insurance companies also tried to shift the blame to the insurance agent who assisted him to purchase the policies. But this attempt to extricate himself from the binding nature of the contractual relationship arising from what had been signed by him is entirely without basis.

[75] In any event, the law does not recognise the convenient and self-serving argument that one does not actually understand what one signs. Certainly not in respect of insurance contracts which demand the utmost good faith as well as full and full disclosure on continuing basis.

[76] The law is settled on the effect of the execution of agreements. Case law authorities are aplenty on this proposition. It binds the parties regardless of whether the parties have read or understood the contents. Thus it is immaterial even if the defendant had not read, let alone understood, any of the terms of any of the documents, in the absence of any allegation of fraud or coercion.

[77] I had the occasion to refer to this principle in the case of *Hap Seng Credit Sdn Bhd v. Mohamed A Ralim & Ors* [2015] 1 LNS 1227; [2016] 10 MLJ 761, as follows:

> [46] I should, for completeness, add that the argument that the respondents had not been in the know of the transactions and that the first respondent having merely signed blank forms and did not understand English, and thus ought not to be responsible for the same is not only unsupported with evidence, but also not justified under the law. It is well-established in the law of contract that a person who is a party to a written contract is bound by the terms of the contract whether or not he understands the language in which it is documented, in the absence of fraud or misrepresentation (see *Subramaniam v. Retnam* [1966] 1 MLJ 172). No allegation of fraud or misrepresentation had been raised, let alone evidenced in the instant case. In the case of *UMW Industries [1985] Sdn Bhd v. Kamaruddin Abdullah & Anor* [1989] 2 CLJ (Rep) 619, the High Court observed pointedly that:
>
> > As for the second defendant's contention that he only signed blank guarantee forms, he has only himself to blame as the plea of *non est factum* does not work in favour of a person who has shown himself to be negligent.
>
> The law cannot thus permit the respondents to be excused from the performance of their expressly stated promise as contained in a valid written agreement on the basis of this contention. The following passage

from the case of *Imbangan Utama Sdn Bhd v. Lotan Engineering Works Sdn Bhd* [2002] 8 CLJ 497; [2002] 2 MLJ 313is no less instructive:

> It really takes a litigant of unusual temerity or cheerful insouciance to register a plea of *non est factum*, for such plea rarely if ever succeeds. There is a whole pack of legal cards stacked against such plea. As a defence or a cause of action the onus rests heavily and onerously on the party who alleges *non est factum*. The signer must establish his lack of competence due to illness or innate incapacity or defective education and he was not negligent or had acted nonchalantly or with want of care (see *Saunders v. Anglia Building Society* [1971] AC 1004 (HL). And, he must further establish that he had thought that he was signing a document which was so radically or fundamentally or basically or essentially different in substance or in kind from the document signed (see also *Polygram Records Sdn Bhd v. Hillary Ang & Ors* [1994] 3 CLJ 806 and *Goh Jong Cheng v. MB Melwani Pte Ltd* [1990] 1 LNS 160; [1991] 1 MLJ 482).

[78] Neither could the defendant be entitled to rely on the defence or plea of *non est factum* because he did not specifically plead such defence. In any event, not an iota of evidence was proffered to establish *non est factum* (see also *Fui Lian Credit & Leasing Sdn Bhd v. Kim Leong Timber Sdn Bhd & Ors* [1991] 1 CLJ 522; [1991] 2 CLJ (Rep) 614). As such, this argument of the defendant trying to escape responsibility from what he had agreed to is wholly unmeritorious.

Other Evidence The Defendant Is Not A Stroke Patient

[79] As if the evidence of the falsity of the insurance claim is insufficient to find liability against the defendant (which is not the case), there are other considerations which in my view would overwhelmingly if not conclusively point to the blatant violation of the defendant's duty of good faith under the relevant insurance contracts with the plaintiff.

[80] First is the very appearance of the defendant in court when he attended to give evidence for himself. Not unmindful that I am not a medical expert, based on my observation, the defendant's appearance and gait was normal. Just like any other witnesses that have given evidence in this court. Despite the first scan and the second scan, the defendant walked unaided and appeared to have no problems at all moving his left limbs.

[81] Secondly, the defendant had also been charged in the Kuala Lumpur Sessions Court under Suit No. WA-62K-99-04-2018 for cheating under s. 420 of the Penal Code based on the police report lodged by PW7.

[82] There are also several criminal charges under the same s. 420 of the Penal Code at the Seremban Magistrate's Court concerning the complaint lodged by the SOCSO which claimed that the defendant had cheated SOCSO of disability pension by claiming that he was a stroke patient with left sided hemiparesis.

[83] In addition, PW5 also testified that Hong Leong Assurance Berhad had also lodged a complaint against the defendant for cheating of insurance benefits on the same pretext of illness and has also been charged on the same.

[84] Thirdly, PW4, the journalist, had also testified that when she was in court to report on the criminal charges against the defendant at the Kuala Lumpur Sessions Court, she had observed that the defendant's appearance and gait appeared normal to her.

[85] Fourthly, PW7 gave evidence that in her inquiries, she had also logged into her Facebook account and was able to access the Facebook pages of the defendant's wife, and a society by the name of Persatuan Kebajikan Daerah Sepang, in respect of which the defendant is stated as the chairman of the same. Photographs which were available for public viewing showed the defendant appearing physically normal. These photographs were mostly taken in 2017 which would be after the time he claimed to have suffered a stroke in 2016.

[86] Fifthly, as mentioned earlier in this judgment, a type 2 traffic summons had been issued to the defendant on 12 September 2016 for committing an offence of driving a vehicle with a blurred number plate somewhere along Jalan Simpang Ampat Alor Gajah Melaka. PW1 testified that this meant that the summons is in defendant's name as owner and the same had been paid by the defendant.

[87] In my judgment, it is clear beyond peradventure that the defendant had in breach of his duty of good faith and other contractual obligations under the policies submitted false claims to obtain insurance benefits from the plaintiff. The defendant's claim that he was a stroke patient is wholly false and deliberately fabricated and contrived.

[88] In his defence, the defendant did contend that he had somewhat recovered as he had done exercise and received traditional medicine treatment. This however is entirely unsubstantiated. In any event, it should be emphasised that as testified by PW11, medically it would be impossible for any person to be completely normal again after having a severe stroke with left side hemiparesis and nerve damage of a permanent nature. It was made clear by PW11 that even if one could look normal, and somehow achieved recovery, the patient could still not walk unaided.

[89] Thus PW11 testified as follows as it appears in the notes of proceedings in tab C p. 43

Question : Would the patient be able to walk? Unaided?

Answer : It depends, depends how bad even the stroke, if the physiotherapy is good, the patient have is motivated, most of them can actually mobilised but with aid.

A Question : With aid.

Answer : Yes.

[90] Evidence that the defendant was not a stroke patient when submission for insurance claims were made by the defendant to the plaintiff has been established. The evidence, as analysed above is both overwhelming and compelling.

B

Whether The Defendant Breached The Policies

[91] It is clear that by reason of the false claims which were made by the defendant intentionally and with deliberate orchestration of a scheme involving other parties who might or might not have themselves been unaware of the fraudulent nature of the same, the defendant had infringed his contractual promise as contained in the relevant policies.

C

[92] And it cannot be emphasised enough that it is now settled law as fairly recently affirmed by the Federal Court in the case of *Sinnaiyah & Sons Sdn Bhd v. Damai Setia Sdn Bhd* [2015] 7 CLJ 584; [2015] 5 MLJ 1 that the standard of proof for civil fraud is on a balance of probabilities.

D

[93] It is only to be expected as it is also contractually stipulated that the defendant owes a contractual and statutory duty to the plaintiff to make full and frank disclosure of all material facts in the proposal form and it is an implied term in the policies that the defendant will not make a claim by fraudulent means and or be in breach of his duty to act in good faith.

E

[94] In the policies, specifically in cl. 7 for instance contains an overriding provision which states as follows:

F

7. CONDITIONS

This Annexure is valid only if this Policy is valid, and this Annexure is subject to the terms and conditions of this Policy unless stated otherwise in this Annexure.

G

7.1 General

7.1.1 The due observation and fulfillment of the terms and conditions of this Annexure of this Annexure by the Life Assured and in so far as they relate to anything to be done or complied with by the Life Assured shall be conditions precedent to any liability of the Company.

H

...

[95] Similarly, in the proposal for assurance which the defendant signed on when agreeing to purchase the policies contain the following binding declaration:

I

IX. DECLARATION AD AUTHORISATION BY LIFE TO BE ASSURED AND PROPOSER

I hereby declare and agreed to the following on behalf of myself and any person or entity who may have or claim any interest in the Policy issued pursuant to this proposal form.

1. All the foregoing statements and answers in this proposal form together with any other documents or questionnaires submitted in connection with this proposal form and all statement made and answers given to the Company's medical examiners, are complete and accurate ("the information") and I understand that the information given by me is relevant to the Company in deciding whether to accept my proposal or not and the rates and terms to be applied. The company may terminate or void the policy contract (if issued), deny or reduce my claim, or change or vary the terms of the policy contract, if there is any-disclosure, misrepresentation, misstatement, inaccuracy or omission.
2. I hereby confirm that save for the relevant sale brochures, sales Illustration and documents duly authorised by the Company, your agent/the FA/the FAR has not given me any document or information to induce me to enter into a contract of assurance with your Company.
3. I understand that any change in the state of health and circumstances of the Life to be Assured between the date of this proposal form and completion of this policy contract, must be communicated in writing to the Company.

...

[96] And that is not all. The parties to an insurance contract like the policies in the instant case are also subject to the provisions of the Financial Services Act 2013, particularly to para. 5 of Schedule 9 to that Act which concerns pre-contractual duty of disclosure for insurance contracts. The following passages from my decision in the case of *Liberty Insurance Bhd v. Marrison Sidar & anor* [2019] 8 CLJ 380; [2018] 6 AMR 893 would suffice to highlight the key obligations that the defendant were subject to and which in the instant case has failed to adhere to:

[40] Subparagraph (8) reads as follows:

(8) Subject to subparagraphs (1) and (3), a consumer shall take reasonable care to disclose to the licensed insurer any matter, other than that in relation to subparagraph (1) or (3), that he knows to be relevant to the decision of the insurer on whether to accept the risk or not and the rates and terms to be applied.

[41] Perhaps most significantly, it is in any event made explicit by paragraph 5 (9) of Schedule 9 that the duty of the utmost good faith on the part of both the insured and the insurer in respect of the dealings with one another continues unaffected by the provisions of the Schedule. Thus, the First Defendant would continue to be under the duty to make the requisite disclosure in adherence to the duty of utmost good faith, even after the Policy had been issued. The provision reads as follows:

(9) Nothing in this Schedule shall affect the duty of utmost good faith to be exercised by a consumer and licensed insurer in their dealings with each other, including the making and paying of a claim, after a contract of insurance has been entered into, varied or renewed.

[97] Indeed, separate from the false claims, the defendant had also not disclosed that he had multiple insurance policies with other insurers when he applied to purchase the insurance policies from the plaintiff. In fact, the income declared was also suspected to be untrue. The defendant had declared in his proposal form that his annual income was RM75,000 for the first policy and RM100,000 for the second policy. On top of that, on both occasions, the defendant represented in the declarations that the defendant had no other existing insurance including those now being proposed to other companies.

[98] But as testimony of the witnesses were recorded in court, it became manifest that when the proposal forms were submitted to the plaintiff, the defendant was already holding policies from Hong Leong Assurance Berhad and AIA Berhad. A potential insured would be specifically asked in the proposal forms if he had other existing insurance, but in this case the defendant concealed the truth.

[99] Again, this blatant failure to have made full and frank disclosure of all material facts in the proposal form represented a form of a breach of the policies given the untrue statement when or suppressed or concealed material fact which he should have disclosed to the plaintiff as the insurer.

[100] The income declared in the various policies varies as well despite the proximity in the dates. And despite the pleading by the plaintiff on the apparent contradictions, the defendant chose not to adduce any evidence of his annual income during the trial, despite his knowledge that the plaintiff has pleaded the inconsistencies in his declared income.

[101] I cannot but agree with the contention of the plaintiff that the proximity in the dates of purchase of the policies and the stroke incident one year later suggest that the defendant did not plan on having a long term commitment. The pattern instead suggests that the purchase of the multiple policies was part of a scheme to defraud various insurance companies.

[102] It is in evidence from the testimony of PW6 and the pertinent documents that the insurance pay-out made by the plaintiff into the Public Islamic Bank account of the defendant amounting to RM1,013,667.69 had been debited and taken out from the account. The defendant's riposte that he had used the cash for treatment and for family expenses is merely a bare assertion without any documentary proof. It is wholly unsubstantiated.

[103] Just like the arguments on his alleged recovery, in respect of his income level as stated in the proposal forms, the defendant has again come short on providing evidential support. This does not help progress the case of the defendant. It has in fact the opposite effect.

[104] In this regard, I should refer to the leading decision of the Court of Appeal in *Juahir Sadikon v. Perbadanan Kemajuan Ekonomi Negeri Johor* [1996] 4 CLJ 1 which reaffirms the rule that "he who asserts must prove", whereby Siti Norma Yaakob JCA (as she then was) instructively held as follows:

> He who alleges must prove such allegation and the onus is on the appellant to do so. See section 103 of the Act. Thus, it is incumbent upon the appellant to produce Tan Sri Basir as his witness to prove the allegation. The fact that the appellant was unable to secure the attendance of Tan Sri Basir as a witness does not shift the burden to the respondent to produce the witness and testify as to what he had uttered, as firstly, the respondent never raised such an allegation and, secondly, has denied even making one. For this very reason, the adverse inference under section 114(g) of the Act relied upon by the appellant cannot be accepted as establishing that if the witness had been produced, his evidence would work against the respondent. There is no obligation in law for the respondent to produce the witness as that obligation rests with the appellant, the party who alleges, and the fact that the appellant was unable to do so is fatal to his case. For this very reason too, the adverse inference under section 114(g) is invoked against the appellant.

[105] This, the defendant plainly failed to establish. As such, in the absence of evidential support and in the face of the testimony and documents exhibited by the plaintiff referred to earlier that strongly suggest the contrary, the case of the appellant is inevitably one that is considerably lacking in merit, if any. These perfunctory, self-serving contentions are of little help to the defendant. And no less crucially the defendant also chose not to call any witnesses to support his defence. He did not call his sister whom he alleged was the driver of the car who actually committed the type 2 summons offence. Neither did he call the two "uncles" who accompanied him for the first two scans or any person to offer any testimony about the recovery he allegedly experienced.

[106] Further, the defendant also did not call any medical expert to even attempt to rebut the overwhelming medical evidence tendered and testified by witnesses of the plaintiff, namely the four doctors, PW10, PW12, PW14 and especially PW11. There is thus justification for the invocation of the presumption in s. 114(g) of the Evidence Act 1950 that the witnesses were not called because their testimony will draw an adverse inference to the defendant's case.

[107] It must be stressed that if the defence of the defendant is that he is a stroke patient, he must produce evidence to support this stance since the plaintiff in its case had shown to the contrary, more so in a fashion that overwhelmingly calls for an equally strong rebuttal from the defendant. That response never truly came.

A *Part Of A Scheme To Cheat Insurance Companies*

[108] In respect of the issue of whether the defendant had purchased the policies as a scheme to make a fraudulent claim against insurers based on a fictitious medical condition, as mentioned earlier, there is evidence that SOCSO and other insurers had had to deal with similar claims of doubtful validity, the police reports and investigation as well as the filing of a number of criminal charges against the defendant for cheating.

[109] Also, PW3, a journalist had covered an event where a press conference was called by the then CCID of the Police director on SOCSO's complaint and the charge against the defendant. The article was written by SP3 based on a press release provided at the press conference which stated that the accused is a chairman of several disabled welfare homes and together with his family members, had filed false claims with SOCSO and four other insurance companies.

[110] All these evidence show that the defendant had used the same *modus operandi* to fraudulently claim for insurance benefits from other organisations as well. However, other than what has been made available to this court as part of the evidence for case of the plaintiff, it is not in my view necessary to further examine this issue for the instant purpose of determining the civil litigation dispute between two parties.

Conclusion

[111] In view of the foregoing reasons and the totality of the evidence, I find that the plaintiff has more than successfully established its case against the defendant on a balance of probabilities. I therefore allow the claim of the plaintiff in terms of encl. 1.